TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Mikhail Fukshansky MD

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-1417-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
January 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $795.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This procedure was denied as included in the EMG/NCS diagnostic testing performed during this office visit. No significant identifiable Evaluation and Management service has been documented, and modifier 25 was not billed with code 99203. Modifier 25 is for a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. Also, the third key component, Medical decision making, is not supported in the documented report. EMG/NCS diagnostic Interpretation is not considered Medical Decision Making – Interpretation of the EMG/NCS is the professional component of those codes and should not be counted as required key component of the E&M."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2016	99203, 95886, 95910, A4556	$795.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X212 – This procedure is included in another procedure, performed on this date
   - B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed
   - 193 – This procedure is included in another procedure performed on this date
   - W3 – This procedure is included in another procedure
   - B13 – The reimbursement is based on the CMS physician fee schedule non-facility site of service rate

Issues

1. Are the insurance carrier's reason for denial of the evaluation and management code supported?
2. Did the carrier make payment per applicable fee guideline?
3. Are supplies separately payable?

Findings

1. The requestor is seeking $795.95 for professional medical services rendered on May 13, 2016. Review of the submitted documentation found claims submitted on May 17, 2016 for codes 99204 and 99203. However, only code 99203 was listed on the DWC060 requesting medical fee dispute resolution. Therefore, this code will be reviewed as part of this dispute resolution.

   The insurance carrier denied Code 99203 as X212 – "This procedure is included in another procedure, performed on this date."

   28 Texas Administrative Code §134.203 (a)(5) states,

   > Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   The Medicare billing policy that speaks to the services rendered is found at www.cms.gov, National Correct Coding Edits. Review of Chapter 1, Section D, finds;

   > *Evaluation and Management (E&M) Services*
   >
   > *All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.*
   >
   > *Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them.* ***A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure.*** *With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure.*

Review of the submitted medical claim finds:

- 99203 – "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family" Global Period (days) – XXX
- 95910 – "Nerve conduction studies; 7-8 studies" Global Period (days) - XXX

As the carrier paid Code 95910, the related code or 99203 is not separately payable. The Division finds the carrier's denial supported.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

   The calculation of the maximum allowable reimbursement for Code 95886 – "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure" is found below;

Billed amount	Allowable	MAR DWC Conversion Factor / Medicare Conversion Factor x Medicare allowable = TX FEE MAR	Carrier Paid	Amount Due
$294.70	$93.26 each	56.82/35.8043 x $93.26 x 2 units = $296.00	$294.70	$0.00 (see below)

3. 28 Texas Administrative Code §134.203 (h) states in pertinent part,

   When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the **least** of the:

   (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount

   The submitted charge or the provider's usual and customary charge was $294.70. The carrier paid this amount. No additional reimbursement is due.

4. The Code A4556 - Electrodes (e.g., apnea monitor), per pair are considered durable medical equipment. This code has a status indicator of "P" or bundled – excluded code. The carrier's denial of B291 – This is a bundled or non-covered procedure based on Medicare guidelines, no separate payment allowed" is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.